		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006767

Facility Name: Beulah Land Christian Home

Address: 201 East Falcon Hwy - Box C (Number) Flanagan (City) 61740 (Zip Code)

County: Livingston

Telephone Number: 815-796-2267 **Fax #** ( )

IDPA ID Number: 37-0841562008

Date of Initial License for Current Owners: 1969

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(C)3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2000 to June 30, 2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Mark Havrilka
(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) William O. Buskirk, CPA
(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624
(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	43	Skilled (SNF)	43	15,695	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	32	Sheltered Care (SC)	32	11,680	5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,375	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,400	8,357	264	15,021	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	1,893	5,383		7,276	12
13	DD 16 OR LESS					13
14	TOTALS	8,293	13,740	264	22,297	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 81.45%

D. How many bed-hold days during this year were paid by Public Aid? 243 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 1970

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 5 and days of care provided 1,825

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	137,768	12,142	13,075	162,985		162,985		162,985			1
2	Food Purchase		114,687		114,687		114,687	(365)	114,322			2
3	Housekeeping	59,900	9,304	2,799	72,003		72,003		72,003			3
4	Laundry	29,735	6,716	1,390	37,841		37,841		37,841			4
5	Heat and Other Utilities			62,422	62,422		62,422	(4,540)	57,882			5
6	Maintenance	25,329		28,502	53,831		53,831	4,553	58,384			6
7	Other (specify):*											7
8	**TOTAL General Services**	252,732	142,849	108,188	503,769		503,769	(352)	503,417			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	741,013	44,487	35,515	821,015	(2,060)	818,955		818,955			10
10a	Therapy			8,255	8,255		8,255		8,255			10a
11	Activities	17,206			17,206		17,206		17,206			11
12	Social Services	47,571	238	7,561	55,370		55,370		55,370			12
13	Nurse Aide Training					2,060	2,060		2,060			13
14	Program Transportation		533		533		533		533			14
15	Other (specify):*			106	106		106		106			15
16	**TOTAL Health Care and Programs**	805,790	45,258	51,437	902,485		902,485		902,485			16
	C. General Administration											
17	Administrative	55,983	2,667	95,052	153,702		153,702	(64,233)	89,469			17
18	Directors Fees											18
19	Professional Services			26	26		26	6,782	6,808			19
20	Dues, Fees, Subscriptions & Promotions			17,121	17,121		17,121	(3,149)	13,972			20
21	Clerical & General Office Expenses	26,007	3,181	51,889	81,077		81,077	(23,913)	57,164			21
22	Employee Benefits & Payroll Taxes			170,240	170,240		170,240	(3,535)	166,705			22
23	Inservice Training & Education											23
24	Travel and Seminar			5,791	5,791		5,791	1,902	7,693			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			14,559	14,559		14,559	799	15,358			26
27	Other (specify):*							3,037	3,037			27
28	**TOTAL General Administration**	81,990	5,848	354,678	442,516		442,516	(82,310)	360,206			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,140,512	193,955	514,303	1,848,770		1,848,770	(82,662)	1,766,108			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Beulah Land Christian Home #0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			122,149	122,149		122,149	(200)	121,949			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			47,601	47,601		47,601	(2,153)	45,448			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			169,750	169,750		169,750	(2,353)	167,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			1,646	1,646		1,646		1,646			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			23,543	23,543		23,543		23,543			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			25,189	25,189		25,189		25,189			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,140,512	193,955	709,242	2,043,709		2,043,709	(85,015)	1,958,694			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(365)	2		4
5	Telephone, TV & Radio in Resident Rooms	(4,850)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(200)	30		9
10	Interest and Other Investment Income	(2,153)	32		10
11	Discounts, Allowances, Rebates & Refunds	(103)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(38,388)	21		24
25	Fund Raising, Advertising and Promotional	(3,482)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (49,541)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,474)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (35,474)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (85,015)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Beulah Land Christian Home

ID# 0006767

Report Period Beginning: July 1, 2000

Ending: June 30, 2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(365)	0	0	0	0	0	0	0	0	0	0	(365)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(4,850)	310	0	0	0	0	0	0	0	0	0	(4,540)	5
6	Maintenance	0	4,553	0	0	0	0	0	0	0	0	0	4,553	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,215)	4,863	0	0	0	0	0	0	0	0	0	(352)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(64,233)	0	0	0	0	0	0	0	0	0	(64,233)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	6,782	0	0	0	0	0	0	0	0	0	6,782	19
20	Fees, Subscriptions & Promotions	(3,482)	333	0	0	0	0	0	0	0	0	0	(3,149)	20
21	Clerical & General Office Expenses	(38,491)	14,578	0	0	0	0	0	0	0	0	0	(23,913)	21
22	Employee Benefits & Payroll Taxes	0	(3,535)	0	0	0	0	0	0	0	0	0	(3,535)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	1,902	0	0	0	0	0	0	0	0	0	1,902	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	799	0	0	0	0	0	0	0	0	0	799	26
27	Other (specify):*	0	3,037	0	0	0	0	0	0	0	0	0	3,037	27
28	**TOTAL General Administration**	(41,973)	(40,337)	0	0	0	0	0	0	0	0	0	(82,310)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(47,188)	(35,474)	0	0	0	0	0	0	0	0	0	(82,662)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Beulah Land Christian Home # 0006767 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(200)	0	0	0	0	0	0	0	0	0	0	(200)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,153)	0	0	0	0	0	0	0	0	0	0	(2,153)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(2,353)	0	0	0	0	0	0	0	0	0	0	(2,353)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(49,541)	(35,474)	0	0	0	0	0	0	0	0	0	(85,015)	45

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached List						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes, Inc.	100.00%	$ 310	$ 310	1
2	V	6	Maintenance				4,553	4,553	2
3	V	17	Administrative	82,896			18,663	(64,233)	3
4	V	18	Directors						4
5	V	19	Professional Services				6,782	6,782	5
6	V	20	Fees, Subscriptions				333	333	6
7	V	21	Clerical				14,578	14,578	7
8	V	22	Employee Benefits	9,539			6,004	(3,535)	8
9	V	23	Inservice Training						9
10	V	24	Travel&Seminar				1,902	1,902	10
11	V	26	Insurance				799	799	11
12	V	27	Depreciation				3,037	3,037	12
13	V								13
14	Total			$ 92,435			$ 56,961	$ * (35,474)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: ne 30, 2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	1996-A GR Bonds	x		1996-A	$1,740.53	07/01/96	$ 225,000	$ 208,575	07/01/21	0.0800	$ 16,808	1
2	Due to CHI Bond Fund	x		Operations	$3,000.00	N/A	121,883	108,834	N/A	0.0850	8,817	2
3	1998-C GR Bonds	x		1998-C	$8,081.11	11/01/98	480,060	310,210	01/05/05	0.0650	21,976	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$12,821.64		$ 826,943	$ 627,619			$ 47,601	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 826,943	$ 627,619			$ 47,601	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ Not applicable	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Beulah Land Christian Home COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0006767

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE (217) 732-9651 FAX #: (217) 732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-13-27-226-004	S27 T28 R3	$ 78.36	$
2.	13-13-27-203-001	S27 T28 R3	$ 211.40	$
3.	13-13-27-201-012	S27 T28 R3	$ 1,260.54	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,550.30	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 30,000 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	16,000	Various	$ 19,470	1
2	Home Office			3,390	2
3	TOTALS	16,000		$ 22,860	3

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	43		1982	1982	$ 1,279,926	$ 31,998	40	$ 31,998	$ 0	$ 609,295	4
5	32		1974	1974	417,998	8,360	50	8,360	(0)	256,257	5
6											6
7	Home Office				24,188	790		790		10,502	7
8											8
	Improvement Type**										
9	Land Improvement			1974			20				9
10	Land Improvement			1977	7,756	155	50	155	0	3,799	10
11	Roof Repairs			1978	5,600		3			5,600	11
12	Insulated Windows			1979	16,273	370	44	370	(0)	8,017	12
13	Smoke Detectors			1979	1,797		15			1,797	13
14	Sewer Line			1980			30				14
15	Ceiling Replaced			1981	1,118	26	43	26		546	15
16	Water Line			1981			30				16
17	Heating & A/C			1982	25,614	1,281	20	1,281	(0)	24,392	17
18	Bldg Improvement			1982	28,428	711	40	711	(0)	13,539	18
19	Parking Lot			1982			15				19
20	Bldg Improvement			1982	7,375	184	40	184	0	3,466	20
21	Landscaping			1982			10				21
22	Bldg Improvement			1982	36,352	909	40	909	(0)	16,889	22
23	Insulation			1983	4,400	147	30	147	(0)	2,719	23
24	Parking Lot			1983			15				24
25	Improvements			1983	2,925	98	30	98	(1)	1,781	25
26	Parking Lot			1983			15				26
27	Landscaping			1983			10				27
28	Parking Lot Lighting			1983			20				28
29	Tiling under Parking Lot			1984			10				29
30	Land Improvement - 1/2			1985			10				30
31	Hot Water System			1985	1,577	79	20	79	(0)	1,297	31
32	Edge Protectors, Etc			1985	507		15			507	32
33	Light Fixtures			1985	406		15			406	33
34	Garage Work			1985	23,170		15			23,170	34
35	Ceiling Tiles			1985	225		15			225	35
36	Bldg Improvement			1986	36,762	919	40	919		14,245	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscape Planter 1/2	1986	$	$	10	$	$	$	37
38	Sidewalks	1987			10				38
39	Light Fixtures - 1/2	1987	610		10			610	39
40	Window 1/2	1987	840	42	20	42		595	40
41	Sidewalks 1/2	1987			25				41
42	Remodeling 1/2	1987	634	42	15	42	0	570	42
43	Hot Water System 1/2	1988	979	49	20	49	(0)	653	43
44	Chg Water Piping 1/2	1988	390	20	20	20	(1)	267	44
45	Water Heater Consult	1988	961	64	15	64	0	848	45
46	Appraisal Fee	1988	3,500	194	15		(194)	3,500	46
47	Fire Alarm Dialer	1988	550	28	20	28		362	47
48	Door Alarm System	1988	1,900	95	20	95		1,219	48
49	Vinyl Siding	1988	3,410	171	20	171	(1)	2,180	49
50	Moving Fire Hydrant	1989			15				50
51	Carpeting	1989	860		5			860	51
52	Door Monitor Panel	1989	1,980		10			1,980	52
53	Compressors (2)	1989	924		10			924	53
54	Compressors	1989	2,306		10			2,306	54
55	Concrete Walk	1989			20				55
56	Painting Sheltercare	1989	1,594		5			1,594	56
57	Compressor (1)	1989	693		10			693	57
58	Outdoor Lighting	1989			10				58
59	Outdoor Lighting	1990			10				59
60	Emerg Power Kitchen Light	1990	329		5			329	60
61	Lavatories/Faucets	1990	1,679		5			1,679	61
62	Carpeting	1990	300		5			300	62
63	Rock	1990			10				63
64	Compressor	1991	1,828	135	10	135		1,828	64
65	Roof Repair	1991	2,340		6			2,340	65
66	Insulating Glass	1991	2,256	68	33	68	0	657	66
67	Smoke/Heat Detectors	1991	885	89	10	89	(1)	853	67
68	Door Monitor	1992	1,440	144	10	144		1,260	68
69	Room Windows (3)	1992	2,696	135	20	135	(0)	1,181	69
70	TOTAL (lines 4 thru 69)		$ 1,958,281	$ 47,303		$ 47,107	$ (196)	$ 1,028,037	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,958,281	$ 47,303		$ 47,107	$ (196)	$ 1,028,037	1
2	A/C Units (5)	1992	5,859	186	8	186		5,859	2
3	Energy Management	1991	658	66	10	66	(0)	572	3
4	Repair and Seal Parking Lot	1993			6				4
5	Sinks/Faucets	1993	537		5			537	5
6	Door Monitor	1993	1,700	170	10	170		1,374	6
7	Mix Valve/Faucet	1993	2,953	295	10	295	0	2,385	7
8	Auto Sprinkler	1993	580	58	10	58		454	8
9	Door Access System	1993	602	60	10	60	0	460	9
10	Wallcoverings	1993	5,315		5			9,539	10
11	Carpet/Wallpaper	1993	9,539		5			4,879	11
12	Drapes	1994	4,879		10				12
13	Roofing Project Shelter	1994	62,189	4,146	15	4,146	(0)	29,022	13
14	Seal Parking Lot	1994			3				14
15	Install Carrier Furnace	1994	1,877	188	10	188	(0)	1,300	15
16	Disposer	1994	1,475	148	10	148	(1)	987	16
17	Landscaping	1995			10				17
18	Nurse Call System	1995	1,040	69	15	69	0	437	18
19	Upstairs Lib/Comp Room	1995	1,743	174	10	174	0	1,104	19
20	Garage Doors	1995	676		5			676	20
21	Wanderguard	1995	4,094	409	10	409	0	2,488	21
22	Smoke/Fire Alarms	1995	957	96	10	96	(0)	584	22
23	A/C Heating Units	1995	2,326	291	8	291	(0)	1,770	23
24	Landscaping	1995			10				24
25	Smoke Detectors	1995	766	77	10	77	(0)	456	25
26	Heating/AC Units	1995	4,652	582	8	582	(1)	3,395	26
27	Carrier Central A/C	1995	2,748	275	10	275	(0)	1,581	27
28	Heating/AC Units	1995	2,326	291	8	291	(0)	1,649	28
29	Water Heater	1996	6,263	626	10	626	0	3,391	29
30	200 Gallon Storage Tank	1996	4,115	412	10	412	(1)	2,197	30
31	Remodel Nursing Wing	1996	3,249	541	5	541		3,249	31
32	Heating/AC Units	1996	5,235	654	8	654	0	3,052	32
33	Parking Lot Lights	1997			5				33
34	TOTAL (lines 1 thru 33)		$ 2,096,634	$ 57,117		$ 56,919	$ (198)	$ 1,111,434	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,096,634	$ 57,117		$ 56,919	$ (198)	$ 1,111,434	1
2	Mixer/Amp	1997	975	98	10	98	(1)	408	2
3	Water Heater	1997	13,453	1,345	10	1,345	0	5,492	3
4	Eyewash Station	1997	555	111	5	111		435	4
5	Exit Lights	1997	1,102	110	10	110	0	422	5
6	Energy Management System	1997	14,670	734	20	734	(1)	2,753	6
7	York C/A Unit	1997	7,839	784	10	784	(0)	2,940	7
8	Floor Covering	1997	1,856	371	5	371	0	1,391	8
9	Wall Covering Sit & Bath	1998	2,574	515	5	515	(0)	1,803	9
10	Floor Covering - Sit & Bath	1998	1,145	229	5	229		782	10
11	Concrt FNC/Dumpster	1998			10				11
12	Carpeting	1998	8,739	1,748	5	1,748	(0)	5,244	12
13	Wallpaper	1998	7,497	1,499	5	1,499	0	4,497	13
14	Landscaping	1998			5				14
15	Room Signs	1998	2,270	454	5	454		1,173	15
16	Paint/Wallpaper/Carpet	1999	17,404	1,740	10	1,740	0	4,350	16
17	Remodel Nurses Station	1999	2,700	180	15	180		390	17
18	Floor Tile/Cove Base	2000	1,144	229	5	229	(0)	420	18
19	Carpet/Cove Base 2 Rooms	2000	576	115	5	115	0	201	19
20	A/C Grill Covers (13)	2000	546	109	5	109	0	182	20
21	Shelter Care Hallway CA	2000	3,686	737	5	737	0	1,228	21
22	Floor Covering	2000	1,040	208	5	208		329	22
23	Fire Alarm System	2000	32,965	3,297	10	3,297	(1)	4,671	23
24	Floor Tile/Cove Base	2000	1,755	351	5	351		497	24
25	Remodel - Chapel/Act/Bs/Dr	2000	10,705	1,071	10	1,071	(1)	1,250	25
26	AC HEATING UNIT INSTALLED	2000	505	23	15	22	(1)	23	26
27	FLOOR COVERINGS	2000	1,143	134	5	133	(1)	134	27
28	ENTRY SYSTEM KEYPAD/ALZ. WING	2001	775	13	5	13	(0)	13	28
29	DOOR ALARM SYSTEM	2001	1,155	10	10	10	(0)	10	29
30	Less Disposals	2001	(9,650)	(222)		(222)		(3,352)	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,225,758	$ 73,110		$ 72,910	$ (200)	$ 1,149,120	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 264,293	$ 32,176	$ 32,176	$	Various	$ 157,951	71
72	Current Year Purchases	50,038	1,826	1,826		Various	1,826	72
73	Fully Depreciated Assets	248,043					248,043	73
74	HO Allocation	21,113	2,179	2,179			17,167	74
75	TOTALS	$ 583,487	$ 36,181	$ 36,181	$		$ 424,987	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	2000 Ford Van	2000	$ 47,500	$ 11,875	$ 11,875	$	4	$ 13,854	76
77										77
78	HO Allocation			4,598	983	983			1,417	78
79										79
80	TOTALS			$ 52,098	$ 12,858	$ 12,858	$		$ 15,271	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,884,203	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 122,149	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 121,949	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (200)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,589,378	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Land	$ 222,338	$	$	86
87	Land Improvements	153,450	3,366	127,486	87
88	OEQT	2,931	47	2,882	88
89					89
90					90
91	TOTALS	$ 378,719	$ 3,413	$ 130,368	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 360

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 360

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,035	$	$ 1,035
2	Books and Supplies				
3	Classroom Wages (a)		225		225
4	Clinical Wages (b)		750		750
5	In-House Trainer Wages (c)		50		50
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 2,060	$	$ 2,060
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,060			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 82,880	$	1
2	Cash-Patient Deposits	4,491		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	79,012		3
4	Supply Inventory (priced at)	17,250		4
5	Short-Term Investments	3,040		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	2,764		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 189,437	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	222,338		13
14	Buildings, at Historical Cost	2,201,602		14
15	Leasehold Improvements, at Historical Cost	153,449		15
16	Equipment, at Historical Cost	612,808		16
17	Accumulated Depreciation (book methods)	(1,674,833)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	437,228		21
22	Other Long-Term Assets (specify):	97,500		22
23	Other(specify):	12,104		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,062,196	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,251,633	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 31,563	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	66,437		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,325		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Reserve for Investment Allowance			36
37	Funds in Trust	4,491		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 104,816	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	627,619		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 627,619	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 732,435	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,519,204	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,251,639	$	48

***(See instructions.)**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,435,960	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,435,960	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	83,244	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 83,244	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,519,204	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,303,628	1
2	Discounts and Allowances for all Levels	(274,091)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,029,537	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	380	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	8,979	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,359	23
	D. Non-Operating Revenue		
24	Contributions	55,602	24
25	Interest and Other Investment Income***	30,335	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 85,937	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Gain/Loss Sale of Equip/Investments	(1,573)	28
28a	Unrealized Holding Gains on Investment	3,693	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,120	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,126,953	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	503,769	31
32	Health Care	902,485	32
33	General Administration	442,516	33
	B. Capital Expense		
34	Ownership	169,750	34
	C. Ancillary Expense		
35	Special Cost Centers	1,646	35
36	Provider Participation Fee	23,543	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,043,709	40
41	**Income before Income Taxes (line 30 minus line 40)****	83,244	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 83,244	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,785	1,785	$ 38,699	$ 21.68	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,111	5,562	117,519	21.13	3
4	Licensed Practical Nurses	9,434	10,067	152,478	15.15	4
5	Nurse Aides & Orderlies	36,572	39,182	409,497	10.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,677	1,677	20,086	11.98	8
9	Activity Director					9
10	Activity Assistants					10
11	Social Service Workers	5,527	5,845	64,777	11.08	11
12	Dietician					12
13	Food Service Supervisor	1,680	1,876	21,706	11.57	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,339	13,795	116,061	8.41	15
16	Dishwashers					16
17	Maintenance Workers	1,656	1,791	25,329	14.14	17
18	Housekeepers	7,967	8,539	59,900	7.01	18
19	Laundry	2,631	2,850	29,735	10.43	19
20	Administrator	1,665	1,733	55,983	32.30	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,793	1,866	21,640	11.60	23
24	Clerical	867	887	7,102	8.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	90,704	97,455	$ 1,140,512 *	$ 11.70	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	142	$ 6,637	1.3	35
36	Medical Director				36
37	Medical Records Consultant	22	1,279	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	0	550	10a.3	39
40	Physical Therapy Consultant	37	2,390	10a.3	40
41	Occupational Therapy Consultant	7	776	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	26	1,665	10a.3	43
44	Activity Consultant				44
45	Social Service Consultant	49	4,234	12.3	45
46	Other(specify)				46
47	PT Assist	33	1,935	10a.3	47
48					48
49	TOTAL (lines 35 - 48)	314	$ 19,466		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Thomas A Novy	Administrator		$ 55,983
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 55,983

B. Administrative - Other

Description	Amount
Mangement Fee	$ 82,896
Marketing	9,540
Allocation of Employee Bonus	2,616
TOTAL (agree to Schedule V, line 17, col. 3)	$ 95,052
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Booth & Antoline	Legal	$ 26
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 27,924
Unemployment Compensation Insurance	5,700
FICA Taxes	87,869
Employee Health Insurance	44,000
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	4,400
Employee Physicals	360
Worker's Comp Medical Expense	(36)
Unemployment Contribution	23
HO Allocation	(3,535)
TOTAL (agree to Schedule V, line 22, col.8)	$ 166,705

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,515
Health Care Worker Background Check	
(Indicate # of checks performed)	
Support	1,373
Maint Fee	2,553
Boiler Inspection & Media Fees	205
Dues	3,938
Notary Renewal Fee	55
HO Allocation	333
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,972

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,328
Seminar Expense	4,238
Other Cost	225
Home Office Allocation	1,902
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,693

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Beulah Land Christian Home # 0006767 Report Period Beginning: July 1, 2000 Ending: June 30, 2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Beulah Land Christian Home **#** 0006767 **Report Period Beginning:** July 1, 2000 **Ending:** June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $3471.71**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **0**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **8,363** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **23,543**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **365**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Shafer & Punke, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will be provided upon completion**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.